

CONFIDENTIAL HEALTH HISTORY

Name: _____ Date: _____ Chart Number: _____

General:

- Headache
- Fever
- Chills
- Night Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of Sleep
- Fatigue
- Nervousness
- Allergy (What)
- Wheezing
- Neuralgia
- Aids/HIV
- Mental Disorder
- Lyme Disease
- Bleeding Problem
- Anemia
- Epilepsy
- Diabetes
- Cancer
- Thyroid Disease/Goiter
- Alcoholism
- Drug Abuse

Muscle and Joints:

- Weakness
- Twitching
- Stiff/Painful Neck
- Backache
- Swollen/Painful Joints
- Tremors
- Numbness/Pain in arm/legs/hands
- Hernia
- Low Back Pain
- Muscle Aches/Soreness
- Spinal Curvature
- Arthritis

Habits:

- Smoking ___ Pks/Day
- ___ Years
- Alcohol ___ Day/Week
- Coffee ___ Cups/Day
- Recreational Drug Use

Respiratory:

- Chronic Cough
- Spitting Blood
- Chest Pain
- Spitting Phlegm
- Difficulty Breathing
- Wheezing/Asthma
- Pneumonia
- Tuberculosis

Eye, Ear, Nose, and Throat:

- Poor Vision
- Crossed Eyes
- Deafness
- Earache
- Ear Noise
- Ear Discharge
- Tonsillitis
- Sinus Trouble
- Nasal Obstruction
- Nose Bleeds
- Sore Throat
- Hoarseness
- Hay Fever
- Frequent Colds
- Enlarged Thyroid

Gastrointestinal:

- Poor Appetite
- Poor Digestion
- Difficulty Swallowing
- Excessive Hunger
- Belching or Gas
- Nausea
- Vomiting
- Vomiting Blood
- Pain Over Stomach
- Ulcer
- Constipation
- Black or Bloody Stools
- Diarrhea
- Colon Trouble
- Hemorrhoids (Piles)
- Liver Trouble
- Jaundice
- Gall Bladder Trouble
- Appendicitis

Cardiovascular:

- Rapid Heart
- Slow Heart
- High Blood Pressure
- Low Blood Pressure
- Pain Over Heart
- Prev. Heart Trouble
- Swelling of Ankles
- Poor Circulation
- Strokes
- Varicose Veins
- Rheumatic Fever
- Irregular Heartbeat

Skin or Allergies:

- Skin Eruptions
- Itching
- Bruising Easily
- Dryness
- Boils
- Sensitive Skin
- Hives/Allergy
- Eczema
- Medicines
- Change in Mole(s)
- Skin Cancer

Genitourinary:

- Frequent Urination
- Painful Urination
- Blood in Urine
- Kidney Infection
- Bed Wetting
- Inability to Control Urine
- Difficulty Starting Urine Flow
- Get Up ___ Times Per Night To Urinate
- Breast Lump or Pain
- Venereal Infection
- Sexual Difficulties

Exercise:

- None
- 1-2 Times/Week
- 3-5 Times/Week
- 6-7 Times/Week

Women Only:

- Birth Control Pills
- Painful Periods
- Excessive Flow
- Irregular Cycle
- Hot Flashes
- Cramps/Backache
- Miscarriage
- Vaginal Discharge
- Pregnant at This Time
- Date of Last PAP _____

Men Only:

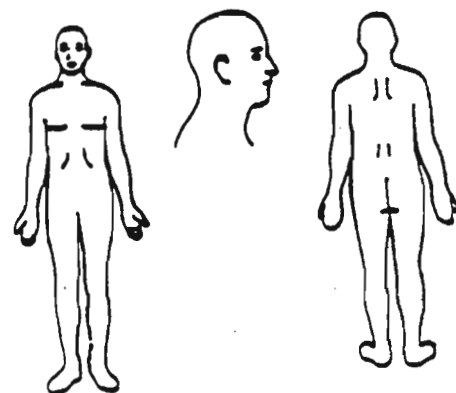
- Testicular Swelling/Pain
- Prostate Problems

Family History: Include information on brothers, sisters, parents, and grandparents)

Do Not Include Yourself.

- Diabetes
- Thyroid Disease/Goiter
- Tuberculosis
- Kidney Disease
- High Blood Pressure
- Heart Disease
- Cancer
- Muscle, Bone, or Nerve Disease

Please Mark Your Areas Of Pain On The Figures Below:



Purpose of This Appointment: _____

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

List Medications You Now Take (Prescriptions): _____

List Any Surgeries: _____